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Efficacy of Post-Hospital Follow-Up with a Heart Failure Nurse Practitioner in Older Adults

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Purpose

The project aim was to determine the efficacy of a Nurse Practitioner (NP)-led heart failure (HF) hospital transitional care discharge program.

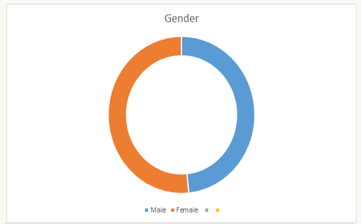
Background

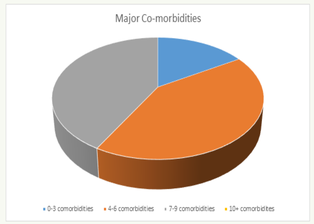
HF is a progressive and debilitating disease that effects millions of Americans each year. It accounts for high rates of emergency room (ER) visits and hospitalizations as well as increased morbidity and mortality (Center for Disease Control and Prevention, 2016). Discharge from an acute hospitalization to the outpatient setting is a vulnerable transition period when appropriate follow-up is key to preventing undue exacerbations and re-hospitalization .

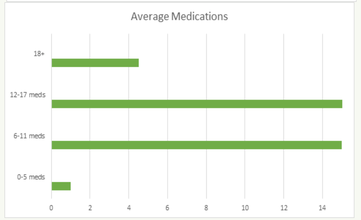
Methods

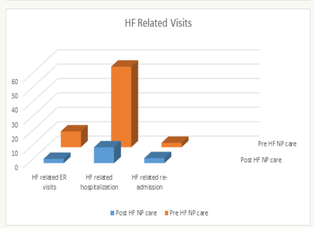
Sixty-three adult patients age 65+ with a diagnosis of HF admitted to two acute care Southwest Washington hospitals were included in retrospective chart review and statistical analysis of HF related ER visits, hospitalizations and re-admissions 3 months pre and 3 months post initial HF-NP follow up visit. Patient had to have been admitted to either hospital and discharged with transitional follow-up care with the HF NP within 30 days.

Results









On average, patients were seen by the HF-NP within 13 days after discharge. Of the 63 patients, 14 (22%) were deceased at time of chart review. Among the patients alive at time of review a significant reduction of 73% in HF related ER visits and a reduction of 79% in HF related hospitalizations was observed during the three months post HF- NP visit, when compared to usual care pre HF-NP. A significant correlation between number of medications and HF related hospitalizations was seen.

Discussion

The findings of this program evaluation and accumulated research supports that timely transitional HF follow-up with and NP who provides individualized patient education and early interventions can reduce ER visits, hospital readmissions and potentially reduce mortality rates (Carlson et al., 2009; Cuomo et al., 2015; Delgado-Passler & McCaffrey, 2006; Frazier et al., 2015; Stauffer et al., 2011).

Next Steps

- Conduct larger study to validate results
- Increase # HF NP providers
- Heart Failure NP appointment at discharge
- Reduce # of days from DC to F/U appointment

References

- Centers for Disease Control and Prevention (2016). *Congestive heart failure*.
- Cuomo, K., Russell, S., Almansa, J., Cummings, A., Rupani, H., & Kotadia, A. (2015). Nurse practitioner run heart failure bridge clinic reduces readmission rates. *Cardiac Failure, 21*(8).
- Delgado-Passler, P., & McCaffrey, R. (2006). The influences of post discharge management by nurse practitioners on hospital readmission for heart failure. *Journal of the American Academy of Nurse Practitioners, 18*(4), 154-160.
- Frazier, S., Baksh, G., & Black, S. (2015). A nurse practitioner run urgent heart failure clinic: Timely treatment can decrease costly hospital admissions/readmissions. *Heart & Lung: The Journal of Acute and Critical Care, 44*(6), 555-556.
- Stauffer, B. D., Fullerton, C., Fleming, N., Ogola, G., Herrin, J., Stafford, P. M., & Ballard, D. J. (2011). Effectiveness and cost of a transitional care program for heart failure: A prospective study with concurrent controls. *Archives of Internal Medicine, 171*(14), 1238-1243.